FORM – 101

Metropolitan Government of Nashville and Davidson County, Record of Occupational Injury/Illness

Reporting:
Fax:
615-515-4838
E-mail:
metroclaims@ascrisk.com

1. Case Number

(SUPERVISOR MUST COMPLETE THIS FORM – ALL SPACES MUST BE COMPLETED)

2. Department	3. Division	4. Re-Injury ☐ Yes ☐ No	5. Date of Report

6. Name of Employee Last First Middle Initial	7.	8. Date of Birth	9. Sex ☐ Male ☐ Female	10. Employee Number

11 Employee Home Address	12 Employee Phone Number Home: Work

13 Date of Injury/Illness	14 Time of Injury/Illness ☐AM ☐PM	15. Exact Address of accident

16. Give full account of duties being performed at time of the Injury/Illness and what caused the injury/illness:

17. Nature of Injury/Illness (cut, bruise, sprain, fracture, etc.)	18. Part of body affected (3rd finger on right hand, lower back, left leg – be specific)

19. Name and address of Medical Facility attended.	20. Was the Employee admitted for overnight stay at Medical Facility? ☐ Yes ☐ No

21 State treatments or medicines given to the employee or prescribed for the employee at above Medical Facility

22. I hereby authorize any Physician or Medical Facility to whom a copy or photocopy of this authorization is delivered to furnish any information, reports, or copies of records which relate directly or indirectly to the above described Injury/Illness the department listed in Number 2 of this form, the Civil Service Medical Examiner for the Metropolitan Government or the Metropolitan Employee Benefit Board or any third party entity contracted to the Employee Benefit Board.

23. Witness of Employee Signature	24. Employee Signature	25. Date:

26. Witness of the Injury/Illness

27. Employee's job classification	28. If Fatality, Date of Death.

29. Name the object or substance that directly injured employee.	30. Would protective clothing or devices prevented or reduced Injury/Illness ☐Yes ☐No	31. Describe protective clothing or devices you recommend.

32 Unsafe condition (no guardrail, no fire extinguisher, etc.)	33. Unsafe act of employee (Inattention to footing, not wearing safety glasses, etc.)

34. Immediate Supervisor: What action have you taken to prevent future similar injuries? (Be specific Do Not Use – Be more careful or just part of the job). Were safety rules violated? If so, what action was taken?

_____
Print Name of Supervisor

Supervisor Contact Phone Number: _____

_____ _____
Signature of Supervisor Date

35. SAFETY COORDINATOR: Is corrective action satisfactory? ☐ Yes ☐ No If no, describe proper action.

_____ _____
Signature of Safety Coordinator Date